PhysioRoam

MOBILE PHYSICAL THERAPY

CONSENT TO TREAT

I, _______________ understand that I will be participating in private, one-on-one physical therapy, incorporating hands-on treatment, manual passive stretching, spinal mobilization, kinesiotaping, and traditional conservative treatment techniques so that I can improve my strength, endurance, flexibility, balance, core strength, and overall health and wellness.

I understand that my physical therapist is licensed in the State of New York, and is educated and highly-trained in the areas above.

By signing below, I am giving my consent to treatment ("informed consent"). And, I also consent for treatment to occur in my home, gym, workplace, hotel room, or other location previously agreed upon.

I have been instructed by my physical therapist to alert my therapist of any special needs, injuries, preferences, or considerations prior to starting the first visit evaluation and treatment, as these could affect my safety and security during the treatment process.

I understand that by signing below, I release this physical therapist of all liabilities for my health and safety during my participation in this treatment process.

I only provide this release with the understanding that my instructor is fully trained and upholds an active license to perform physical therapy in the State of New York.

Print Name: __________________________________ Date of Birth: ________________

Address: ______________________ City, State: _________________ ZIP: ___________

Phone Number: ________________ Email:_____________________________________

Signature: ____ Date: ________________

Parent/Guardian Signature:__________________________ Date:____________________
Name of Parent/Guardian:____

MOBILE PHYSICAL THERAPY

FEDERAL HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

PhysioRoam

mobile physical therapy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

"We: refers to PhysioRoam mobile physical therapy. "You" or "yours" refers to any individual receiving treatment by PhysioRoam mobile physical therapy employees.

Federal law - means the Health Insurance Portability and Accountability Act and related privacy rules -- requires PhysioRoam mobile physical therapy) to keep your health information private. We are not allowed to use or disclose it unless we receive your permission or unless permitted by law. Federal law requires us to give you this Notice of our legal duties and privacy practices. This Notice is to inform you of uses and disclosures of your health information that we may make. It also informs you of your rights and our duties with regard to this health information.

We must follow the terms of this Notice. We do reserve the right to change the terms of this Notice and make the new Notice provisions apply to all the health information we keep. This includes health information we had prior to any change in this Notice. We must promptly change this Notice when there is a material change to our uses or disclosures, your rights, our duties and other related circumstances. To receive such Notices by email, you should tell the contact listed at the end of this Notice.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Federal law permits us to use and disclose protected health information for purposes of treatment, payment and health care operations as those terms are defined under federal law. We will comply with any state or federal law that is more restrictive as to our uses and disclosures of protected health information.

There are also times when federal law permits or requires us to use or disclose your information without your written permission.

Additionally, where appropriate, we may disclose protected health information to a group health plan or plan sponsor in accordance with federal law.

Permitted Disclosures:

We may not make all of the uses and disclosures listed here, but federal law permits use or disclosure of your information without your permission

- When we disclose your information to you.
- To third party non-PhysioRoam mobile physical therapy associates that perform services for us or on our behalf.

• Where disclosure is required by law.
• To a public health authority authorized by law to collect or receive your information to prevent or control disease, injury or disability or when reviewing reports of child abuse or for the conduct of other authorized public health activities and responsibilities.
• To a health oversight agency for such activities.
• For judicial and administrative proceedings.
• To a law enforcement official for a law enforcement purpose.
• To a medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties authorized by law.
• To organ donor organizations in order to aid in such donations.
• For certain research purposes authorized by and subject to federal law.
• To avert a serious threat to health or safety.
• To government officials regarding military personnel and certain domestic and foreign government officials for certain functions authorized by federal law.
• To comply with workers' compensation and other similar programs.

Required Disclosures

We must disclose your information when required by the Secretary of the Department of Health and Human Services to make sure we comply with federal law.
We are also required, with certain exceptions, to provide you with access to inspect and obtain a copy of your information that we keep. See "Federal Law Provides You with the Right to Inspect and Copy Protected Health Information" below.

INDIVIDUAL RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO REQUEST RESTRICTIONS:

You have the right to request that restrictions be placed on certain uses and disclosures of your information. We are not required to agree. If we do agree, we may not use or disclose any of your information except where you need emergency treatment. We may end an agreement to restrict as allowed by federal law. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO ALTERNATIVE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION:

If you choose to have your information sent to you by a means of your choice or to an address of your choice, we will do so if the request is reasonable. You must clearly state that disclosure of all or any part of your information could endanger you if not sent per your choice. Any such request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO INSPECT AND COPY PROTECTED HEALTH INFORMATION:
You have the right to inspect and copy your information, certain
information relating to civil, criminal, or administrative proceedings, and certain information prohibited by law from disclosure. Any request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO A PAPER COPY OF THIS NOTICE:
You have the right, even if you have agreed to receive notice by email, to get a paper copy of this Notice. All requests should be in writing and sent to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO FILE A COMPLAINT:
If you believe your privacy rights have been violated, you have the right to complain to us by writing to the contact listed at the end of this Notice. Federal law prohibits retaliation against you for filing such a complaint. The contact listed at the end of this Notice is also available to provide you information regarding questions you have or other information concerning this Notice.

THE CONTACT TO WHOM YOU SHOULD ADDRESS YOUR COMPLAINT IS:

PhysioRoam - mobile physical therapy
Kiley Holmes, PT, DPT, OCS, SCS, FAAOMPT
631-403-8208
PhysioRoam@gmail.com

Effective August 15, 2018

PhysioRoam

MOBILE PHYSICAL THERAPY

Name: ____ DOB:_______________
Height:_______ Weight: _______ Occupation: _______________________________________

Living environment: ____________________________________ Do you live alone? Yes No

If no, who do you live with:____

Home Environment

___Stairs with Railing ___Stairs without Railing ___Ramps___Elevator___Uneven Terrain ____Other: ____

General Health

Do you use: ____Cane____Walker /rollator ____Wheelchair ____Other___________________

How would you rate your general health: _____Excellent _____Good _____Fair _____Poor

Health Habits

Do you exercise regularly? ________ Yes _______No

If yes, how often and what type of activities?____

____

Family History (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/ grandfather had any of the following disorders and provide age of onset if known)

Heart disease: _________________________Hypertension:______________________________

Stroke: _______________________________Diabetes: ________________________________

Cancer:_________________________________Other: ________________________________

Medications

Do you take any prescription medications? ___ Yes ___ No

Please list:____

____

____

MOBILE PHYSICAL THERAPY

Past Medical History

Please explain if you have ever had:

High blood pressure__________________

Arthritis___________________________

Blood disorders_______________________

Broken bones_______________________

Cancer______________________________

Vascular problem_____________________

Depression__________________________

Infectious disease (such as tuberculosis, hepatitis)____________________________

Kidney problems______________________

Low blood sugar______________________

Lung problems ______________________

Multiple sclerosis ____________________

Osteoporosis_________________________

Developmental problems ______________

Diabetes____________________________

Stroke______________________________

Thyroid problems_____________________

Parkinson's diseases__________________

Seizures/epilepsy_____________________

Heart problems_______________________

Current Limitation (Check all that apply)

___ Difficulty with bed mobility

___ Difficulty with transfers

___ Difficulty walking on level surface

___ On stairs

___ On ramps

___ On uneven terrain

___ Difficulty with self-care

___ Difficulty with household chores, shopping, driving

___ Difficulty work/school

___ Difficulty recreation or play

History of Current Problem(s)

When did the problem(s) begin?
____/____/____ What occurred?

____

____

____

Have you ever had the problem(s) before?

___ Yes ___ No

What did you do for the problem(s)?

____
____
____

Did the problem(s) get better?

___ Yes ____ No

About how long did the problem last?

____

What makes the problem better / worse?

____
____
____

What activities are you not able to do now that you could do before the problem(s)? (Please be as specific as you can)

____
____
____
____
____

Rate the level of your pain on the following scale (0-10).

At present: _____

At best: _____

At worst: _____

Patient Specific Functional Scale:

List 3-5 activities that are the most limiting for you to do at the moment:

1:_____________________________

2:_____________________________

3:_____________________________

4:_____________________________

5:_____________________________

Insurance Information

Do you have Medicare: Yes:___ No: ___

Acknowledgements, Financial Responsibility, Cancellations

"We": refers to PhysioRoam mobile physical therapy or affiliates. "I" refers to any individual receiving treatment by PhysioRoam mobile physical therapy or affiliates.

Release of Information:
We are authorized to release pertinent medical information to your referring physician.
We are authorized to release medical information to your insurance company regarding coverage for services performed with the patient.

HIPAA Acknowledgement:
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices as required by HIPAA.

Guarantee of Payment/Financial Responsibility/Insurance:
Payment is due at the time of service.
I agree to pay PhysioRoam mobile physical therapy in full at the end of each treatment session, unless otherwise agreed upon by both parties in writing.
I understand that any outstanding balance is my/our responsibility. I agree to pay the balance within 14 days of receipt of invoice (unless a payment plan has been discussed and agreed upon beforehand).

Cancellations:
I understand that if I am unable to attend a scheduled appointment, I am required to cancel the appointment by email or call PhysioRoam mobile physical therapy) 12 hours prior to the said appointment; otherwise a fee of 100% of the agreed appointment fee will be incurred for late cancellations. This full-rate fee is required because another patient, who needs treatment, could have been scheduled and treated in this time slot.

Insurance Coverage:
Services without a referral might not be covered by the patient's health plan or insurer, but may be covered with a referral. Call your insurance company and let us know what you need to make sure that you are able to be reimbursed.

Consent:

By signing my name below, I verify that I have read and agree to the information contained in this packet and that the information I have provided is true and accurate.

Patient's name:____ Date: _____________

Patient's signature ____

Responsible Party name: _____________________________Relationship:________________

Responsible Party Signature: ________________________________Date:________________

SQUARE AVAILABLE

Visa and Mastercard accepted

Referral Information

How did you hear about us?____

If by a friend or family member, please give their phone number and address below that we may send a thank you note and small gift

____

____

If you were referred by a Physician:_________________________________

Do you have a follow-up appointment with this physician?_________________

If yes, when? ____